LOS ANGELES COUNTY COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

January 19, 2016

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC *(cont.)*	COMM STAFF/CONSULTANTS
Al Ballesteros, MBA, *Co-Chair*	Abad Lopez	Phil Curtis	Carolyn Echols-Watson, MPA
Michelle Enfield	Miguel Martinez, MPH, MSW	Susan Forrest	Jane Nachazel
Bradley Land	Raphael Péna	Isabel Garcia	
Mario Pérez, MPH	Julio Rodriguez	Bridget Gordon	
Ricky Rosales	LaShonda Spencer, MD	Guilder	**DHSP STAFF**
Yolanda Sumpter		James Harris	Michael Green, PhD, MHSA
		Charles Hilliard	Pamela Ogata
	PUBLIC	Joseph Holsinger	
	Diana Aguayo	Nkechi Johnson	
	Jeff Bailey	Charles Maddox	
	Brian Beneat	Anthony Mills, MD	
	Jason Brown	Katja Nelson	
	Aaron Culpepper		

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1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *1/19/2016*
2) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *12/15/2015*
3) **Table**: Service/Intervention Recommendation, *10/27/2014*

1. **CALL TO ORDER**: Mr. Land called the meeting to order at 1:15 pm.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION #2: Approve the 12/15/2015 Planning, Priorities and Allocations (PP&A) Committee meeting minutes, as presented **(*Passed by Consensus*)**.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)***:
   - Mr. Hilliard supported extending case management options. Spectrum in South Los Angeles offers the Linkage To Care (LTC) program, but it has been restrictive. Many clients do not receive care at DHSP-funded clinics and often return to Spectrum for case management services it cannot provide since LTC eligibility requires being out of care for seven or more months.
   - Some mental health clients also have severe case management needs. Even some of those receiving Medical Care Coordination (MCC) at DHSP-funded clinics cannot always receive the level of support they need.

5. **COMMITTEE COMMENT *(Non-Agendized or Follow-Up)***: There were no comments.

6. **CO-CHAIRS' REPORT**:
   A. **Co-Chair Open Nominations/Election**:
      - Mr. Ballesteros and Ms. Enfield were previously nominated. There were no additional nominations.
      - The body thanked Mr. Land for his many years of service as PP&A Co-Chair.

      Motion 2A: (*Rosales/Land*): Elect Al Ballesteros and Michelle Enfield as Planning, Priorities and Allocations (PP&A) Committee Co-Chairs **(*Passed by Consensus*)**.

   B. **Comprehensive HIV Plan (CHP) Update**: Mr. Land reported no new updates since the Commission meeting.

7. **LOS ANGELES COORDINATED HIV NEEDS ASSESSMENT (LACHNA) UPDATE**:
   - Dr. Green, Chief, Planning, Division of HIV and STD Programs (DHSP), said recruitment started in December 2015. Eight of 11 staff identified by DHSP to conduct interviews are trained and working in eight HIV clinics to assist in recruitment and review HIV surveillance data. Start of work at four more clinics was pending Institutional Review Board (IRB) approval.
   - DHSP was reviewing sample size to determine if it can be reduced based on uptake of potential participants. The response was not high enough to make that determination at this point, but the minimum sample size should be reached by March 2015. DHSP was adding data collection team staff to expedite recruitment and increase the number of patients interviewed.
   - The LACHNA team will be working with the Medical Monitoring Project (MMP) team to contact non-Ryan White HIV clients. That was not part of the original data collection strategy, but it expands access to PLWH receiving care at non-DHSP-funded sites. MMP is an annual survey of physicians nationwide funded by the Centers for Disease Control and Prevention (CDC).
   - The Health Resources Services Administration (HRSA) requires each jurisdiction to perform a needs assessment every three years. Normally that is done by the Planning Council (Commission). Historically, the Commission has conducted LACHNA in conjunction with DHSP to assess service needs of PLWH and those at risk. The Commission uses information to inform the Priority- and Allocation-Setting (P-and-A) process while DHSP uses data to identify service gaps.
   - Mr. Land asked why DHSP was considering reducing the sample size and considerations for deciding. Dr. Green replied sample size is a biostatistics issue. The bigger the sample size the more likely researchers will have a representative sample of the population so the more reliably they can infer findings. The only reason to reduce sample size is for expediency. If the response rate is sufficient, lowering the sample size will help finalize the data set for 2016 planning purposes.
   - The current sample size was 340. DHSP's last data run was to review how confidence levels would be affected at 200.
   - To date, 54 people have been contacted and less than 20 surveys done. Initial sampling methodology was to sample HIV surveillance data for a random sample of PLWH countywide. DHSP has not used that approach before except for MMP so there is no historical response rate. It will take another few weeks to see how many PLWH approached will take the survey.
   - DHSP contacts PLWH identified through HIV surveillance via their clinics. Staff are stationed at clinics mainly for that reason.
   - The Ryan White application is due in either late September or early October. DHSP needs to report that a needs assessment was conducted and how. PP&A also needs to complete its P-and-A to inform the application. P-and-A utilizes LACHNA data, but also data from other sources such as that being compiled by the CHP and DHSP's Service Utilization Report (SUR).

8. **FINANCIAL REPORT**: Committee members identified their conflicts of interest.
   A. **Allocation Strategies for MCC and Non-Medical Case Management for Care and Prevention for Unaligned Patients**:
      - Mr. Pérez, MPH, Director, DHSP, reported approximately a $10 million investment in MCC. Historically, there was also Psychosocial Case Management (CM), a staple of case management at the time. Several years ago, the Commission began to explore other forms of case management especially since many providers were not co-located at medical care sites and often providers could not confirm how many of their patients were in medical care.
      - Consequently, the MCC model was developed, primarily by the Commission. The model added a Registered Nurse (RN), Social Worker (SW) and case aide to medical care clinic teams specifically to address medical care retention barriers.
      - MCC was now generally in place though a few programs were still ramping up. MCC teams were clearly having an impact as measured by a lower proportion of PLWH lost to care and a higher proportion who are virally suppressed.
      - MCC teams are, however, unable to leave the clinic to seek out those who may have been lost to care. The concept of "MCC with legs" is to add an outreach component for that purpose. DHSP has 25% delegated authority to amend its contracts with Ambulatory Outpatient Medical (AOM) and MCC providers. DHSP has begun the process to increase all MCC contracts by 25% over their face amount for an approximately $2.5 million investment effective 3/1/2016.
      - Historically, DHSP would have an agency by agency conversation on staffing needs, staffing patterns and use of funds. At this point, a blanket approach will be used to move funds as quickly as possible with refinements later, as needed.

- Regarding Non-Medical CM, there is a small set of agencies that are mostly historical Psychosocial CM providers, but not AOM providers or not at the time Psychosocial CM was revised to the current Linkage CM (LCM) pilot program. One provider has since added an HIV medicine component not funded by DHSP.
- The LCM pilot has served a low number of clients with 78% of those linked to care. The cost was substantial and reflects an annual investment of $700,000 to $800,000. DHSP was deliberating now on efficacy of the program.
- Mr. Bailey, Client Services, AIDS Project Los Angeles (APLA), could not speak for other providers, but APLA's LCM program was successful. It had linked 60 people to care as of December who it could track. At least another 50 people were also linked, but were not eligible for LCM. Some were ineligible because they had been in care in Texas or Nevada. Another client was recently released from jail. His parole officer contacted APLA and he was linked, but APLA does not have a Transitional CM contract so could not count the person.
- Many clients APLA has reached are PLWH who have not touched the system before and often do not want to be found. Often they come to APLA for supportive services because it is the first name that appears in an internet search.
- Mr. Harris was born HIV+ and had been in and out of care over the years. He has been a client of APLA for a year after having been out of care for five or six years. Physicians tend to only provide viral loads and dispense medication. APLA provides support. They follow-up with clients, know their names, ask how they are doing and if they have eaten. Because of the support, it is the longest he has been in care at one place which has likely saved his life.
- A Spanish-speaking man said he came to the US in 2007 and worked many years at a large company. He lost his job due to his immigration status. He found another job, but it lacked medical care. He tested HIV+ at a clinic which provided referrals, but the cost was too high. He paid taxes since arriving in the US, but only APLA has provided needed services.
- Mr. Bailey agreed $700,000 is a great deal of money, but the lifetime cost of a PLWH not virally suppressed is estimated to be $350,000. Savings would be significant if APLA's LCM program only helped two PLWH become virally suppressed.
- Mr. Pérez noted there are many forms of CM: MCC; Psychosocial; Transitional, serving inmates on their release; LCM, expressly designed to link PLWH to care; Outreach; Referral; Youth Transitional; and the Linkage and Re-engagement Program (LRP). All these seek to engage PLWH in various ways with different outcome expectations. Dr. Green and his team will be reviewing these models including whether areas of overlap are appropriate.
- The Commission de-prioritized Psychosocial CM and allocated it no funds. DHSP insisted on modifying scopes of work for Psychosocial CM contracts about to sunset in order to address County linkage case management needs. Those LCM contracts are due to sunset 2/29/2016. There is a one-time 12-month renewal option which must be decided on soon.
- In making that decision, it is important to be clear on what functions are being supported. For example, a person who calls to find a physician and is referred with no follow-up on the appointment has received a Referral service, not CM.
- Wendy Garland, MPH, and her team evaluated the LCM program based on results of performance metrics over time. She can present what was learned based on the data though agency-specific discussions are not appropriate.
- It is important not only to fund services, but to fund those with impact to move the needle in ending AIDS. Every life is important, but funding is limited so services must have a significant reach to impact the epidemic as a whole.
- Dr. Mills asked about MCC/LCM differences. Mr. Pérez replied a patient at an AOM site with an MCC team has a physician, Physician Assistant (PA) or RN in addition to the MCC team RN, SW and case aide to address psychosocial issues that prevent PLWH from remaining in care, e.g., adherence, addiction, housing insecurity and homelessness, mental illness and access to support services. Mission creep often develops in agencies with the temptation to use the MCC RN and SW to do, e.g., vitals. DHSP follows-up with agencies to ensure MCC staff are used appropriately.
- The MCC team cannot, however, leave the clinic to locate a patient who has not been seen in six months. The proposed additional $2.5 million would fund agencies to add an outreach worker to the MCC team for that work.
- MCC does not assist PLWH not in care at a clinic, e.g., those new to the area and seeking a place to live. They will do an internet search and call the first agencies that appear. That is where an outreach or referral component can play a role.
- Non-Medical CM is typically not in a clinic-based setting. Looking at what menu of services they should provide is important. Seven agencies are currently funded for LCM and services could be extended to help fill gaps.
- Five agencies provide Transitional CM for the 400 PLWH in jail. Agencies are expected to work with inmates to develop an appropriate post-release referral plan. The model was being rethought due to issues with plan follow-through.
- Two agencies provide Transitional CM for Youth to bring PLWH youth out of care into care. Youth advocates would meet with Mr. Pérez on 1/22/2015 to discuss how to improve that CM model.
- The LRP model will rely specifically on HIV surveillance data to track PLWH out of care and work with the system to re-engage them. County Counsel did not approve DHSP's request for Community Based Organization (CBO) access to surveillance data so DHSP staff will access the data and trained outreach staff will find and re-engage the PLWH.
- DHSP continually questions whether it can purchase a better, more relevant, more cost effective product.

- Mr. Land felt eligibility for MCC seems to have tightened since the Commission envisioned it and developed a standard. As procured and deployed, it seems to have narrowed access to the system of care rather than broaden it. He supported expansion, but wanted to ensure 100% access and psychosocial support, e.g., via support groups. He was unsure what exactly was needed, but sought more inviting, warm access. Perhaps LACHNA would inform options.
- Mr. Pérez clarified that MCC is available to all PLWH regardless of the payer source for their care. MCC teams assess and prioritize PLWH for services based on acuity, e.g., someone at risk of not returning or not remaining adherent. PP&A has previously discussed if MCC should be available regardless of acuity, but that would entail greater costs.
- Ms. Forrest noted she previously worked at APLA when "Living Skills" provided television and coffee. There were no expectations, but people came to break their isolation. She noted Mr. Harris did not talk about medical issues or MCC, but about APLA staff who saw he was having a bad day and asked if he was hungry. That is not a service per se, but it should be kept in mind that a simple connection may keep PLWH in care - not only quality of care, MCC or linkage.
- Ms. Gordon questioned whether agencies would offer services for her demographic if she called, i.e., African-American women who may not look as though they need help. She was interested in linkage numbers for that population.
- Mental health services are also essential to support linkage especially at diagnosis. Even those without a substance use issue may seek out substances when diagnosed. Mental health and nutrition support are critical.
- As a parent, she cannot always afford Medicare co-payments and clinic hours can be an issue because of child care.
- Ms. Sumpter recommended emphasizing diversity among new linkage to care staff so they better reflect their clients.
- Regarding a timeline, Mr. Pérez said DHSP was finalizing a formal request to extend LCM contracts past expirations on either 3/1/2016 or 4/1/2016. DHSP will meet with PP&A Co-Chairs in the next few weeks to review YR 25 projections through 2/29/2016 and shortly after discuss YR 26 P-and-A with PP&A including Psychosocial CM/LTC/Outreach.
- Dr. Green added DHSP can extend LCM contracts, but not increase Psychosocial CM for YR 26 given solicitation realities. The challenge is to identify which of the eight Non-Medical CM programs will best reach the people who need to be reached and engage them in medical care. Once in care, MCC is charged with keeping them there. Target populations and which services best support them need to be determined. He noted Outreach is a separate category.
- Dr. Mills asked about the rationale for originally defunding Psychosocial CM. Mr. Land said there were then Medical CM in AOM environments and Psychosocial CM. Creating the MCC model required reviewing the system to identify funding and the two were merged for that purpose. It was understood it might need to be revised to meet unanticipated issues once launched. Meanwhile, the Affordable Care Act (ACA) launched causing more change in the landscape to consider.
- Ms. Nachazel added DHSP brought a great deal of data showing many PLWH used Psychosocial CM as an end in itself rather than entering medical care. Research had shown the importance of ensuring PLWH entered medical care and became adherent to medications to achieve viral load suppression both for their health and to reduce new infections.

➲ PP&A Co-Chairs Ballesteros and Enfield will meet with Mr. Pérez or his designee to strategize on potential Non-Medical Case Management investments and approaches to contracting them. They will report back at the February PP&A.

➲ Mr. Bailey will provide data from a recent APLA needs assessment on Non-Medical CM for the February PP&A meeting.

Motion 2A: (*Land/Sumpter*): The Planning, Priorities and Allocations Committee supports investment in Non-Medical Case Management for Program Year)PY) 2016 **(*Passed: Ayes,*** Enfield, Land, Maddox, Pérez, Sumpter, Ballesteros; ***Opposed,*** None; ***Abstentions,*** None**)**.

9. MEDICAL CARE COORDINATION (MCC):

A. Feasibility of Establishing Partnerships with Non-DHSP-funded AOM Clinics to Fund MCC Teams:

- Mr. Pérez noted there are two options to move this expansion proposal forward. One approach would be to develop a Request for Proposals (RFP). That would take longer. DHSP was already working on a Mental Health services RFP. Two prevention-focused RFPs were recently released which will generate work once applications are received. A Language services Invitation For Bids (IFB) was also developed to fill gaps and Part 2 of a Request for Statement of Qualifications (RFSQ) on biomedical interventions was due to be released soon. DHSP was also working on Oral Health, MCC and AOM Sub-Specialty RFPs. Work already scheduled means an RFP option would likely not result in services until PY 2017.
- The other procurement option historically used to address this kind of situation with available resources and a significant need is sole source contracts. They can be completed much more quickly and have been a valuable complement to RFPs. The Board of Supervisors, however, has made it clear that it has very little appetite for them.
- Consequently, DHSP cannot advocate for that option from its role as County employees. To the extent an accelerated timeline is sought, the Commission needs to understand those limitations and act accordingly.
- He added there was a recent exceptionally quick RFP process for biomedical interventions, but that was due to a motion by the Board requiring a response in 45 days. The County RFP process normally takes seven plus months.

- Mr. Curtis asked if the Board would support a Commission request. Mr. Pérez replied the Board would not necessarily support a request. The Commission may, however, say that given the need to expand MCC access and the resources available that it can be expanded to non-DHSP-funded AOM contractors. The Commission can urge the Department of Public Health (DPH) and the Board to explore all options to accomplish that. DHSP cannot advocate on the matter.
- Dr. Mills asked if funds would be lost due to the length of the RFP process. Mr. Pérez replied the Commission vote late last year allowed maximization of YR 25 Ryan White Part A, YR 24 Minority AIDS Initiative (MAI) while rolling over YR 25 MAI and spending down $6.5 of $8.5 million in Ryan White Part B funds. CDC funds will also be maximized.
- The next due date will be Net County Cost expenditures on 6/30/2016 for approximately $6 million. DHSP was likely to maximize that, but savings continue to be created on a rolling basis. Resources need to be invested now, not 18 months from now. The system is not spending as much money as it used to and at some point resources may be lost.
- Dr. Mills noted Dr. Sonali Kulkarni, Medical Director, DHSP, presented impressive data at the Medical Advisory Committee on the performance of Ryan White versus other clinics. Ryan White clinics serve a population that is more challenging to treat with greater inequities and stigma, but still achieve higher retention in care and viral suppression rates. As a physician, he finds that a strong incentive to assist clients in non-DHSP-funded clinics as quickly as possible.
- Mr. Land said his Supervisor's Office has not supported sole source, but would be more likely to support a rapid RFP process such as that for biomedical interventions. Mr. Pérez replied it was important to recognize that DHSP resources were limited. Other RFPs/IFBs would need to be put on hold if this were prioritized. The Commission should ensure any advocacy considers all the ramifications and is consistent across Board Offices.
- Contracts and Grants, DPH, now does all RFPs. DHSP pays for five staff. Three are hired and a fourth will start soon.
- ➲ PP&A Co-Chairs will meet with Mr. Pérez or his designee on strategies to procure MCC for non-DHSP-funded medical clinics as well as potential investments for the service and report back at the February PP&A meeting.

B. **Expansion of Existing MCC Programming to Include Intensive Outreach Component Beginning 3/1/2016 (PY 26)**:

- Expansion was previously discussed under Item 8, but Ms. Sumpter urged also evaluating services to ensure they are reaching underserved populations. That was especially important as current contractors will be receiving more funds.
- ➲ Wendy Garland, MPH, DHSP, will present an MCC update at the February PP&A meeting.

Motion 3: Approve the expansion of existing MCC programming up to the maximum delegated authority to include an intensive outreach component including staff for field psychosocial outreach beginning March 1, 2016 (Program Year 26) **(*Passed: Ayes,*** Enfield, Land, Maddox, Pérez, Sumpter, Ballesteros; ***Opposed,*** None; ***Abstentions,*** None**)**.

10. NEXT STEPS: There was no additional discussion.

11. ANNOUNCEMENTS: There were no announcements.

12. ADJOURNMENT: The meeting adjourned at 3:00 pm.